

HEALTH CARE QUALITY IMPROVEMENT ACT: PEER REVIEW, PROCEDURE, PROCESS, AND PRIVACY

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ABSTRACT

The Health Care Quality Improvement Act (HCQIA, or the Act) provides powerful immunities for hospitals and others in the peer review process that subject health care professionals to “Professional Review Actions.” The law was passed in part in response to a Supreme Court case involving the inappropriate use of the physician peer review process. Now, over thirty years later, the scope of immunity under the HCQIA is still evolving, and HCQIA and its rules are increasingly interacting with other areas of law. For example, in our increasingly litigious world, Alternative Dispute Resolution or ADR concepts may prove a useful mechanism to resolve HCQIA and peer-review related disputes. In light of increased focus on privacy, it is important to review how HCQIA and peer review can interact with various privacy rules, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended.

This Article first reviews the legislative history and health-care policy of the Act as well as recent case law interpreting the Act. The Article then focuses on the procedural protections under the Act and how ADR procedures may offer guidance on bolstering due process protections. Finally, the Article discusses HCQIA’s interaction with HIPAA and other privacy issues that may arise in litigation involving peer review.

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I. INTRODUCTION

The Health Care Quality Improvement Act of 1986 (HCQIA or the Act) generally provides immunity to certain participants in the resolution of the standard of care or other staff-privileging issues for health care professionals. HCQIA was passed in 1986 as a means to discourage litigation against medical professionals when they participated in the peer-review process, where certain due process protections are provided to the individual under review. Today, peer

review is all-pervasive, and medical staff members/professionals are routinely evaluated for competency and professional judgment. Yet, there has been a serious reevaluation as to whether the policies associated with HCQIA are still valid—does the Act continue to achieve its original purposes? Questions courts interpret under the Act involve the dynamic interplay among confidentiality of peer review activities, due process requirements for participants, and disclosure of information to patients.

This Article will discuss the health-care environment in the context of HCQIA. First, the Article reviews the legislative history and health-care policy of the Act and recent case law interpreting the Act. The review of case law includes opinions from both the federal and state courts that have interpreted the Act. The Article then focuses on the procedural protections under the Act and how Alternative Dispute Resolution (ADR) procedures may offer guidance on bolstering due process protections. Finally, the Article discusses the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other privacy issues that may arise in litigation involving peer review.

II. WHY HCQIA: LEGISLATIVE HISTORY

A. *Patrick v. Burget*

As with many laws, a case prompted the passage of HCQIA—*Patrick v. Burget*.¹ The facts in *Patrick* involved Dr. Timothy Patrick, who was trained in both general and vascular surgery.² After his initial one-year contract expired with the Astoria Clinic (Clinic), he was asked to become a partner.³ Because he felt he had not been paid in proportion to the income he had produced for the Clinic, he chose instead to open an independent practice in Astoria.⁴ The Clinic doctors reacted negatively to Dr. Patrick's establishment of an

1. *Patrick v. Burget*, 486 U.S. 94 (1988).

2. *Patrick v. Burget*, 800 F.2d 1498, 1505 (9th Cir. 1986), *rev'd on other grounds*, 486 U.S. 94 (1988) (stating that plaintiffs must show that “the legislature contemplated the kind of activity complained of. That is, it must be clear that the legislature intended to replace competition with regulation” (citations omitted)).

3. *Patrick v. Burget*, 800 F.2d at 1502.

4. *Id.*

independent practice.⁵ As such, Dr. Patrick received virtually no surgical referrals from the Clinic.⁶

During a period in which there was no general surgeon at the Clinic, patients were referred to hospitals 50 or more miles away for surgery.⁷ Clinic doctors reacted angrily when Dr. Patrick treated a "Clinic patient," and the evidence showed several examples of confrontations resulting from the perceived theft of patients.⁸ Some of these confrontations took place in front of the patients themselves.⁹ The Clinic doctors also were not interested in helping Dr. Patrick with his own patients.¹⁰ Clinic surgeons consistently refused to enter into cross-coverage agreements with Dr. Patrick that would provide care for each other's patients if any of them were unavailable to see patients.¹¹ Clinic doctors were also reluctant to give consultations.¹² Meanwhile, they repeatedly criticized Dr. Patrick for failure to get outside consultations and adequate backup coverage.¹³

A disciplinary action was triggered against Dr. Patrick.¹⁴ Several medical charts of patients who ostensibly were treated by Dr. Patrick were given to the medical executive committee.¹⁵ A partner of the Clinic chaired the committee, and two Clinic partners testified against Dr. Patrick before the committee.¹⁶ The evidence demonstrated that the Clinic doctors targeted Dr. Patrick's cases for peer review and criticized his cases more often than those of other surgeons.¹⁷ Ultimately, Dr. Patrick's privileges were terminated.¹⁸

Dr. Patrick was allowed a hearing at which the executive committee presented the case against him, and he presented a defense.¹⁹ The charges against Dr. Patrick were drawn up at a

5. *Id.*

6. *Id.*

7. *Id.*

8. *Id.*

9. *Id.*

10. *Id.*

11. *Id.*

12. *Id.*

13. *Id.*

14. *Id.* at 1503.

15. *Id.*

16. *Id.*

17. *Id.* at 1503–04.

18. *Id.* at 1504.

19. *Id.*

meeting, within the Clinic board room, attended by the hospital administrator and an attorney appointed by the hospital to represent the executive committee.²⁰ In the end, Dr. Patrick was stripped of his staff privileges.²¹ He then filed a lawsuit against the partners of the Clinic.²² Dr. Patrick based his lawsuit on violations of the Sherman Act and interference with prospective economic advantage under Oregon law.²³

The jury awarded Dr. Patrick \$650,000 for the antitrust violations, which the court trebled.²⁴ The jury awarded \$20,000 in compensatory damages and \$90,000 in punitive damages on the state law claim; the court awarded \$228,600 in attorney's fees.²⁵ In total, Dr. Patrick was awarded over two million dollars. Ostensibly, the message sent to the medical community from this verdict was that physicians should be afraid to participate in peer review for fear of retaliatory litigation. Yet, what is missed in this superficial conclusion is that the case was not about peer review but about former partners using the peer-review process for financial advantage.²⁶

Even with the passage of HCQIA, these facts raise issues as to whether immunity protection should be given under HCQIA. By today's standards, the result in Dr. Patrick's peer-review hearing could easily be challenged based upon the fact that the physicians, who participated in Dr. Patrick's peer review, were biased and had financial incentives to terminate Dr. Patrick's hospital privileges.

B. *Passage of the Health Care Quality Improvement Act*

There were many policy reasons why Congress passed the HCQIA.²⁷ The *Patrick* case highlighted Congress's concern that hospitals or doctors required immunity from litigation when they performed "peer reviews or challenges to professional conduct where patient care is at issue."²⁸ "HCQIA was adopted out of concern 'that medical professionals who were sufficiently fearful of the threat of

20. *Id.*

21. *Id.*

22. *Id.*

23. *Id.*

24. *Id.* at 1504–05.

25. *Id.* at 1505.

26. *Id.* at 1506.

27. 42 U.S.C.A. §§ 11101–11152 (Westlaw 2016).

28. *Cohlmya v. St. John Med. Ctr.*, 693 F.3d 1269, 1276 (10th Cir. 2012).

litigation will simply not do meaningful peer review, thus leaving patients at the mercy of people who should have been corrected or removed from their positions.”²⁹ This Congressional intent is evident from statements made at legislative hearings:

The purpose of this legislation is to improve the quality of medical care by encouraging physicians to identify and discipline other physicians who are incompetent or who engage in unprofessional behavior.

Under this bill, hospitals and physicians that conduct peer review will be protected from damages in suits by physicians who lose their hospital privileges, provided the peer review actions meet the due process and other standards established in the bill. In addition, hospitals and physicians that discipline doctors will be required to report these disciplinary actions to the state medical boards.³⁰

Thus, in exchange for the broad grant of immunity, HCQIA requires that any disciplinary action taken against a doctor is reported to the National Practitioner’s Database (NPDB). Indeed, HCQIA provides that a health care entity can forfeit the immunity provided by HCQIA for up to 3 years if it fails to report any action which adversely affects the clinical privileges of a physician for a period longer than 30 days or accepts the surrender of clinical privileges of a physician while the physician is under an investigation for incompetence or improper professional conduct.³¹ However, the law requires an extensive administrative process—which includes an investigation by the Department of Health and Human Services along with notice and an opportunity to object—before the immunity can be revoked.³²

In fact, Congress may have viewed the reporting requirements as part of the price to be paid for the broad grant of immunity. The District Court, in *Anderson v. Eastern Connecticut Health Network*, specifically noted the specific relationship between HCQIA’s reporting requirement and the immunity grant:

29. *Id.* (quoting IB PHILLIP E. AREEDA & HERBERT HOVENKAMP, ANTITRUST LAW 19 n.1 (3d ed. 2006)).

30. H.R. REP. NO. 99-903, at *2 (1986), 1986 WL 31972.

31. 42 U.S.C.A. § 11111(b) (Westlaw 2016).

32. *Id.*

The creation of the NPDB was central to Congress’s statutory scheme: NPDB reporting aims to ensure that hospitals and state medical boards receive critical information about the physicians they employ and license. In Congress’s judgment, any “professional review action[] related to professional competence or conduct” that adversely affects privileges for more than thirty days bears sufficiently on a physician’s credentials to require reporting.³³

The Court noted that Congress provided immunity with respect to reports made to the NPDB, specifically to ensure that accurate information about practitioners could be relayed across state lines:

Congress thought reporting so important to the HCQIA that it immunized health care entities against suits arising out of reports made in good faith 42. U.S.C § 11137 (c), offered a more limited form of immunity for professional review bodies and their members in suits arising out of professional review actions 42. U.S.C § 11137 (a) (1), and authorized sanctions against health care entities that fail to observe their reporting obligations 42. U.S.C § 11137 (c) (1).³⁴

Thus, Congress recognized that immunity from damages liability in lawsuits for participation in peer review—and the accompanying national reporting scheme—would encourage medical professionals to voluntarily engage in this process with hospitals. In exchange, immunity offered a means to foster the relationship between these two health care factions—professionals and hospital administrators—to promote better health care. The congressional record shows that this was an explicit trade in the minds of legislators, when it states that “[t]o assure that the medical profession cooperates in this system, the Committee believes it is essential to provide some legal immunity to doctors and hospitals that engage in peer review activities.”³⁵

33. *Anderson v. E. Conn. Health Network, Inc.*, No. 3:12-cv-00785, 2015 WL 4393552, at *1 (D. Conn. July 16, 2015).

34. *Id.*

35. H.R. Rep. No. 99-903 at *2, 3.

III. HCQIA IN ACTION IN THE COURTS

A “professional review action” is defined under HCQIA in pertinent part as “an action or recommendation of a professional review body which is taken or made in the conduct of professional review activity, which is based on the competence or professional conduct of an individual physician . . . and which affects (or may affect) adversely the clinical privileges . . . of the physician.”³⁶ “The term ‘adversely affecting’ includes reducing, restricting, suspending, revoking, denying, or failing to renew clinical privileges or membership in a health care entity.”³⁷ For purposes of this Article, peer review will be synonymous with a professional review action under the Act.

The thrust of many legal battles under HCQIA addresses the four prongs of the statute and whether a peer review is given immunity under the Act.³⁸ HCQIA provides that hospitals and other participants are immune from claims for damages during a peer review if the following requirements are met: (1) the reason for the peer review is patient care; (2) the peer review is based on a reasonable investigation; (3) the physician was given fair process during the peer review; and (4) the investigation justifies taking an adverse action against the physician.³⁹ As a statutorily created immunity, HCQIA is most commonly raised in a motion for summary judgment or motion to dismiss.

In such a motion, the physician who was subject to peer review, and who wants to overcome the hospital’s HCQIA immunity, has the burden of proving that requirements were not met “by a preponderance of the evidence.”⁴⁰ “A professional review action will be presumed to have met the preceding standards necessary for immunity to attach unless the presumption is rebutted by a preponderance of the evidence.”⁴¹ This presumption “creates an unusual standard for reviewing summary judgment orders, as the plaintiff bears the burden of proving that the professional review

36. 42 U.S.C.A. § 11151(9) (Westlaw 2016).

37. *Id.* § 11151(1); *see also* 45 C.F.R.A. § 60.3 (Westlaw 2016).

38. *See infra* at Part III.

39. 42 U.S.C.A. § 11112(a) (Westlaw 2016).

40. *See Wahi v. Charleston Area Med. Ctr.*, 562 F.3d 599, 607 (4th Cir. 2009) (citing 42 U.S.C.A. § 11112(a) (Westlaw 2016)).

41. *E.g.*, *Gordon v. Lewistown Hosp.*, 423 F.3d 184, 202 (3d Cir. 2005) (citing 42 U.S.C.A. § 11112(a) (Westlaw 2016)).

process was not reasonable and thus did not meet the standard for immunity.”⁴²

Two recent cases, *Wahi v. Charleston Area Medical Center, Inc.* and *Miller v. Huron Regional Medical Center, Inc.*, illustrate the difficulty that this “unusual standard for reviewing” can create. In *Wahi*, the medical center did not comply with its own internal bylaws in conducting a peer review.⁴³ Yet, the court held that viewing the totality of the circumstances in an objectively reasonable manner showed that the physician was given fair procedures during his peer review hearing.⁴⁴ Thus, the court ruled, questions under HCQIA as to whether the burden of production is met include whether objective evidence supports the finding made by participants in the peer review action and whether the physician was afforded adequate process based on the totality of the circumstances.

Similarly, in *Miller*, Dr. Miller alleged that the Huron Medical Center (HRMC) disregarded its bylaws’ procedural mandates relating to corrective action. Specifically, Dr. Miller argued that the Medical Center requested that Dr. Miller “voluntarily” reduce her surgical privileges without providing a formal hearing.⁴⁵ The court framed the question simply: “the court must determine whether [Dr. Miller] satisfied [her] burden of producing evidence that would allow a reasonable jury to conclude that [HRMC’s] peer review disciplinary process failed to meet the standards of HCQIA.”⁴⁶ As an evidentiary matter, the Court ruled that Dr. Miller adduced sufficient evidence to establish that HRMC was required to provide her with due process, but did not.⁴⁷ Thus, HRMC’s peer review fell outside the ambit of HCQIA’s immunity provisions, and Dr. Miller’s case could proceed.⁴⁸ Although *Wahi* ruled that that the Hospital was immune under HCQIA and *Miller* ruled that the Hospital was not immune under HCQIA, in both cases the Hospital carried an initial presumption of immunity under HCQIA. The Court then required the physician challenging the immunity to bear the burden of disproving the elements of immunity.

42. *Id.*

43. *Wahi*, 562 F.3d at 602.

44. *Id.* at 614.

45. *Miller v. Huron Reg’l Med. Ctr. Inc.*, 145 F Supp. 3d 873, 880 (D.S.D. 2015).

46. *Id.* at 888 (internal quotations omitted).

47. *Id.*

48. *Id.*

A. “In Furtherance of Patient Care”: Is Patient Care the Reason for Peer Review?

The first element that a physician must disprove in order to defeat HCQIA immunity examines whether “Patient Care” is the reason for the peer review. This prong for establishing HCQIA immunity requires that patient care must be the reason for peer review.⁴⁹ Many factual situations may give rise to a finding that patient care is the reason for peer review, including a physician’s failure to provide accurate records of a patient’s diagnosis and the failure to provide timely care,⁵⁰ a physician’s lack of poor judgment and skill in performing a surgery,⁵¹ and a physician’s failure to participate in evaluations as required by the Medical Executive Committee.⁵² Indeed, overall concerns based on the totality of the circumstances and not any individual patient issue may constitute a valid reason to initiate a peer-review action based on patient care.⁵³

While case law seems to suggest that every aspect of a physician’s conduct in the hospital may constitute sufficient reasons to institute peer review based on patient care, the more complicated issue is whether patient-care reasons exist to institute peer review based on a physician’s conduct outside the hospital. In *Moore v. Williamsburg Regional Hospital*,⁵⁴ the Fourth Circuit Court of Appeals examined this issue. In *Moore*, the physician was a general surgeon and the Department of Social Services filed a complaint

49. 42 U.S.C.A. § 11112(a)(1) (Westlaw 2016) (stating that, for the purposes of immunity, a peer review must be “in the reasonable belief that the action was in the furtherance of quality health care”).

50. *See, e.g.*, *DeKalb Med. Ctr. v. Obekpa*, 315 Ga. App. 739, 740 (2013) (terminating a doctor and placing him on the NPDB for failure to provide accurate records of patient diagnosis and failure to provide timely care).

51. *See, e.g.*, *Randall v. Amisub of South Carolina Inc.*, 2014 WL 7008507, at *9 (S.C.C.P. 2014).

52. *See, e.g.*, *Johnson v. SSM Healthcare Sys.*, 988 F. Supp. 2d 1080, 1082 (E.D. Mo. 2013).

53. *Burrowes v. Northside Hosp.*, 671 S.E.2d 176, 178 (Ga. App. 2008); *see, e.g.*, *Braswell v. Haywood Reg’l Med. Ctr.*, 234 F. App’x 47, 54–55 (4th Cir. 2007) (finding that under the circumstances, the hospital did not violate the doctor’s constitutional rights or lose its immunity under the HCQIA if the summary suspension of his privileges was necessary to protect patient safety); *Patel v. Midland Mem’l Hosp. & Med. Ctr.*, 298 F.3d 333, 340 (5th Cir. 2002) (holding summary suspension of cardiologist’s clinical privileges did not violate due process because doctor’s “methods posed a danger to patient safety”).

54. 560 F.3d 166 (4th Cir. 2009).

against him for sexual abuse of his minor, adopted daughter.⁵⁵ The Department eventually decided to dismiss the complaint because of the trauma to the minor child in having to testify in the proceeding.⁵⁶

The hospital became aware of the allegations of sexual abuse and began a peer review investigation of the physician.⁵⁷ The hospital suspended the physician's staff privileges because of the potential risk to patients treated by the physician.⁵⁸ The court upheld the hospital's decision, stating "[a] physician's competence can be implicated by conduct outside a health care facility if there is a clear nexus between the conduct and the ability to render patient care."⁵⁹ *Moore* suggests that a physician's private conduct may have a spillover effect on the physician's professional life if there is a reasonable connection between the physician's private conduct and his professional conduct.⁶⁰ However, *Moore* rejected that all private conduct of a physician could be the basis of peer review:

It can be argued, of course, that almost any form of private misconduct may have some conceivable impact on a physician's performance, but no fair reading of the statute (with its emphasis upon competence and professional conduct) would indicate Congress intended to go nearly so far. Human beings are not smooth and rounded pebbles, but often contradictory in their habits and traits. A surgeon whose personal life might not bear close scrutiny may nonetheless save lives with his talents in the operating room.⁶¹

Other illustrations may include situations where a physician has substance abuse or alcohol-abuse problems, but the physician does not show any signs of impairment while on staff at the hospital. Obviously, conduct involving substance abuse or alcoholism may be subject to peer review, even if occurring on non-work hours because of the risk that such abuse passes to patients. *Murphy v. Goss*⁶² is

55. *Id.* at 168–69.

56. *Id.* at 170.

57. *Id.* at 169.

58. *Id.*

59. *Id.* at 172.

60. *Id.*

61. *Id.* at 173.

62. 103 F. Supp. 3d 1234 (E.D. Or. 2015).

illustrative. In *Murphy*, a physician was on cardiac call requiring “the physician to be available for telephone consultation, scheduling surgeries with hospital staff, or to report to the hospital for acute surgical emergencies.”⁶³

One night while on call, the physician drank one or two glasses of wine at a restaurant.⁶⁴ The hospital board found that consuming alcohol while on cardiac call placed the physician at risk of impaired function, and, as such, “constitutes conduct ‘which does or might adversely affect a physician’s . . . ability to safely and skillfully practice medicine. . . .’”⁶⁵ The hospital reprimanded the physician, finding that the physician “subordinated the best interest of his patients to his own personal desires.”⁶⁶ The Court upheld the board’s decision.⁶⁷ Thus, the *Murphy* case demonstrates that a physician’s personal conduct outside the hospital may be a legitimate basis for peer review because such conduct can be a risk to patient care.

B. “Reasonable Effort to Obtain the Facts”: Was the Investigation Reasonable?

The second prong for establishing HCQIA immunity requires the hospital to make a reasonable effort to obtain the relevant facts before initiating a peer review.⁶⁸ HCQIA does not provide any definitive guidelines as to when an investigation is reasonable. In *Brandner v. Bateman*,⁶⁹ the Court explained that the Act does not require a hospital to “carry out its investigation in any particular manner; it is only required to conduct a factual investigation that is reasonable under the circumstances.”⁷⁰ Indeed, the inquiry as to whether an investigation is reasonable depends upon whether the “totality of the process” leading up to the peer review action is reasonable under the circumstances.⁷¹ The Court stated, quite simply,

63. *Id.* at 1237.

64. *Id.*

65. *Id.* (quoting OR. REV. STAT. ANN. § 677.188(4)(a) (Westlaw 2016)).

66. *Id.* at 1237–38.

67. *Id.* at 1242.

68. 42 U.S.C.A. § 11112(a)(2) (Westlaw 2016) (stating that, for the purposes of immunity, a peer review must be “after a reasonable effort to obtain the facts of the matter”).

69. 349 P.3d 1068 (Alaska 2015).

70. *Id.* at 1073 (quoting *Cowell v. Good Samaritan Cmty. Health Care*, 225 P.3d 294, 305 (Wash. Ct. App. 2009)).

71. *Johnson v. SSM Healthcare Sys.*, 988 F. Supp. 2d 1080, 1089 (E.D. Mo. 2013).

that the physician “is entitled to a reasonable investigation under the Act, not a perfect investigation.”⁷²

Hospitals usually have great latitude in how an investigation is conducted leading up to a peer review. In general, the courts look at whether the hospital engaged in a good-faith effort to obtain the relevant facts to determine if there is a basis to initiate a peer-review action. Some of the factors considered by courts in deciding whether a hospital’s investigation was reasonable include: (1) whether the investigation involved inquiry into relevant, unbiased facts; (2) whether the investigation involved allowing the physician to present rebuttal evidence; (3) whether the physician interviewed during the investigation;⁷³ and (4) whether witnesses interviewed about the incident in question.⁷⁴

The question of what constitutes an investigation under the Act may also arise. In *Doe v. Leavitt*,⁷⁵ the Court deferred to the Secretary of Health and Human Services for a definition of investigation.⁷⁶ The Court stated an “investigation is . . . considered ongoing until the health care entity’s decision making authority takes a final action or formally closes the investigation.”⁷⁷ The Court did not discuss when an investigation begins but did provide some insight by stating that an investigation includes “each of the discrete activities that a hospital undertakes during the course of its investigation.”⁷⁸ In *Doe*, the Court identified the following as examples of an investigation: accepting a complaint, deciding to investigate, appointing an investigating committee, conducting fact gathering, and preparing a report.⁷⁹ Thus, at a minimum, a fact-gathering process should be initiated in order to fall within the definition of an investigation under HCQIA.

72. *Brandner*, 349 P.3d at 1074.

73. *Obey v. Frisco Med. Ctr.*, No. 4:13–CV–656, 2015 WL 417425, at *8 (E.D. Tex. Jan. 30, 2015).

74. *Smigaj v. Yakima Valley Mem’l Hosp. Ass’n*, 269 P.3d 323, 334 (Wash. Ct. App. 2012).

75. 552 F.3d 75, 85 (1st Cir. 2009).

76. *Id.* at 77.

77. *Id.* at 78.

78. *Id.* at 84.

79. *Id.*

C. “Adequate Notice and Hearing Procedures”: Was Due Process Provided?

The third prong for establishing HCQIA immunity requires that the physician be given fair process during peer review.⁸⁰ A physician is entitled to the basic procedure of notice of a hearing.⁸¹ The physician also has the rights: (1) to representation by an attorney or other person of the physician’s choice; (2) to have a record made of the proceedings; (3) to call, examine, and cross-examine witnesses; (4) to present relevant evidence regardless of its admissibility in a court of law; and (5) to submit a written statement at the close of the hearing.⁸² After the hearing, the physician has the right to receive the written recommendation of the arbitrator, officer, or panel, including a statement of the basis for the recommendations, and to receive a written decision of the health-care entity, including a statement of the basis for the decision.⁸³

Of the four prongs, the physician’s procedural rights prong is one of the most litigated. In *Hurwitz v. AHS Hosp. Corp.*, the court determined that a fair peer review proceeding occurs when: (1) the physician is given multiple opportunities to provide written submissions to the hospital’s reviewers and decision-makers; (2) the physician is notified of the specific patient cases that would be the subject of review before the formal hearing was conducted by the hearing panel; (3) the physician is represented in the internal hearings by able and experienced counsel who is a certified civil trial attorney; and (4) the physician testifies and also presents his own expert witness.⁸⁴

Some hospitals have argued that compliance with hospital bylaws shows compliance with the HCQIA. For example, in *Peper v. St. Mary’s Hospital and Medical Center*,⁸⁵ a cardiothoracic surgeon had

80. 42 U.S.C.A. § 11112(a)(3) (Westlaw 2016) (stating that, for the purposes of immunity, a peer review must be “after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances”).

81. 42 U.S.C.A. § 11112(b) (Westlaw 2016).

82. 42 U.S.C.A. § 11112(b)(3)(C) (Westlaw 2016).

83. 42 U.S.C.A. § 11112(b)(3)(D) (Westlaw 2016).

84. *Id.*

85. 207 P.3d 881 (Colo. App. 2008); *see also* *Wieters v. Roper*, 58 F. App’x 40, 46 (4th Cir. 2003) (HCQIA immunity dependent on a hospital following its bylaws); *Meyers v. Logan Mem’l Hosp.*, 82 F. Supp. 2d 707, 715 (W.D. Ky. 2000) (HCQIA does not require a hospital to follow its bylaws). *But see* *Islami v.*

several of his cases reviewed by an external reviewer without his knowledge.⁸⁶ The external reviewer was unclear as to conclusions and requested films of other patients for further review, which were not provided to the reviewer.⁸⁷ Dr. Peper's privileges were then terminated effective immediately without prior notice.⁸⁸ A letter stated that termination from the medical staff under the bylaws did not require a hearing.⁸⁹ Dr. Peper brought a federal suit alleging, among other things, anticompetitive conduct.⁹⁰ The defendants responded to the suit based upon immunity under HCQIA and the district court granted the hospital's motion for summary judgment.⁹¹

On appeal, the appellate court focused on the due process prong of HCQIA, stating that "defendants indisputably took final action adverse to Dr. Peper without providing any notice [that] his conduct even was under review. They provided Dr. Peper no opportunity to be heard before revoking his privileges and reporting him to the state medical board and the national data bank."⁹² The hospital argued that Dr. Peper waived his HCQIA procedural rights by applying for provisional hospital privileges and agreeing to be bound by bylaws that provided that no hearing rights were to be given to provisional staff.⁹³ The Court rejected this argument:

Just as noncompliance with hospital bylaws does not show noncompliance with the HCQIA, compliance with hospital bylaws does not show compliance with the HCQIA. This is because a peer review disciplinary action does more than terminate one physician-hospital relationship. Indeed, Congress intended the HCQIA [statute] to address "a national need to restrict the ability of incompetent physicians to move from State to State without disclosure or discovery of the

Covenant Med. Ctr., 822 F. Supp. 1361, 1377 (N.D. Iowa 1997) (fair notice and hearing if hospital followed bylaws).

86. *Peper*, 207 P.3d at 884.

87. *Id.*

88. *Id.*

89. *Id.*

90. *Id.*

91. *Id.*

92. *Id.* at 888.

93. *Id.* at 888.

physician's previous damaging or incompetent performance."⁹⁴

There are no bright-line rules as to the procedural requirements that should be given to a physician during peer reviews. Yet, there are some generalities that can be made to determine whether peer-review procedures will comport with HCQIA. At a minimum, physicians should not be abruptly summoned before a peer-review committee without warning and summarily stripped of their privileges for no articulated reasons.⁹⁵ To the contrary, a peer review decision should be the culmination of a deliberate and considered process, one in which the physician had many opportunities to present opposition and, presumably, to settle the matter on the terms recommended in succession by the internal reviewers.⁹⁶

D. *“Reasonable Belief That the Action Was Warranted”*: Do Facts Support Action?

The fourth prong for establishing HCQIA immunity requires the facts to support initiating a peer review against a physician.⁹⁷ Courts recognize that a “reasonable belief” standard applies to this prong of the Act.⁹⁸ It requires that health-care participants believe their actions would further quality health care and are warranted by the facts available to them.⁹⁹ Courts have held that the standard is based on an objective test:

The “reasonable belief” standard is satisfied “if the reviewers, with the information available to them at the time of the professional review action, would reasonably have concluded that their actions would restrict incompetent behavior or would protect patients.”¹⁰⁰

94. *Id.* at 889 (referring to 42 U.S.C.A. § 11101(2) (Westlaw 2016)).

95. *See id.* at 888.

96. *Hurwitz*, 103 A.3d at 303–04.

97. 42 U.S.C.A. § 11112(a)(4) (Westlaw 2016) (stating that, for the purposes of immunity, a peer review must be “in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts”).

98. *See, e.g., Peper*, 207 P.3d at 887.

99. *Id.* at 885.

100. *Parmintuan v. Nanticoke Mem’l Hosp.*, 192 F.3d 378, 389 (3d Cir. 1999); *see also Mathews v. Lancaster Gen. Hosp.*, 87 F.3d 624, 635 (3d Cir. 1996)

Essentially, the “reasonable belief” standard is fact sensitive. In general, the peer review should not be based on false and misleading documents which are prepared without knowledge of all of the relevant facts. The evidence should include the following: (1) information provided by the doctors, nurses, and medical personnel who have knowledge of the physician’s care; (2) each stage of review should justify actions taken against the physician for the alleged conduct; and (3) personal bias and economic competition should not color the peer review.¹⁰¹

In summary, the peer review must be examined in its totality and the entire multi-step, fact-finding process should satisfy the HCQIA standard. There should be objective reasonableness. *Summers v. Ardent Health Services*¹⁰² is instructive. In *Summers*, the court stated that the physician’s allegations of bad faith and the failure of the ad hoc committee to interview the caseworker or patient at one stage of the peer-review process did not meet the “reasonable belief” standard. The court stated:

Plaintiff must do more than identify one part of the investigation—the failure of the ad hoc committee to interview Patient B and the caseworker—that could have been more thorough . . . or argue that the peer review action was taken in bad faith . . . Plaintiff must identify fallacies in the fact-finding process that render it unreasonable as a whole.¹⁰³

IV. HOW DOES HCQIA INTERFACE WITH ALTERNATIVE DISPUTE RESOLUTION?

HCQIA requires that any hearing must be conducted by an arbitrator, a hearing officer, or panel of individuals who are not in direct competition with the physician.¹⁰⁴ At its core, HCQIA emphasizes that the hearing officer, who presides over the peer review, should be neutral and “not in direct economic competition with the physician involved.”¹⁰⁵ In general, hospitals may select other

(quoting H.R. REP. NO. 99-903, at 10 (1986), as reprinted in 1986 U.S.C.C.A.N. at 6393).

101. *Johnson v. Christus Spohn*, 2008 WL 375417, at *8 (S.D. Tex. 2008).

102. 257 P.3d 943 (N.M. 2011).

103. *Id.* at 951.

104. 42 U.S.C.A. § 11112(b)(3)(A)(i)–(iii) (Westlaw 2016).

105. 42 U.S.C.A. § 11112(b)(3)(A)(iii) (Westlaw 2016).

physicians on staff at the hospital or another high-level hospital employee to preside over a peer review. From a physician's standpoint, using hospital staff may be problematic because of the physician's perception (correct or not) that other staff physicians have an innate economic incentive to deprive another physician of staff privileges.¹⁰⁶ Moreover, high-level hospital employees are even less neutral because their compensation and livelihood is closely tied to the hospital. Thus, ADR should offer an excellent alternative to resolve peer review issues.

A. *Alternatives in Dispute Resolution: Which Process Works Best?*

When considering the use of ADR, it is important to review the variety of alternatives to traditional dispute resolution or litigation. For example, in the full spectrum of ADR, negotiation is at one end of the continuum, allowing the parties in the dispute to resolve their issues directly with each other. This allows for the greatest control of the process by the parties, and the greatest flexibility in outcomes but does not guarantee certainty of the resolution.¹⁰⁷ The undesired outcome of negotiation could be that of an impasse, where no agreement is reached.

At one end of the spectrum, mediation, has become the often-used alternative to direct negotiation, whereby a neutral third party can assist the parties in their negotiation to produce an agreement that is mutually acceptable.¹⁰⁸ The mediator often helps the disputants focus on their mutual and separate interests, explores a variety of options to meet those interests, and helps each recognize the costs of not reaching an agreement.¹⁰⁹ Many times, that alternative may be worse than a purported compromise resulting in mutual agreement.¹¹⁰

106. *Chudacoff v. Univ. Med. Ctr.*, 954 F. Supp. 2d 1065, 1082 (9th Cir. 2013) (stating the court's recognition that peer review committees are more susceptible to political influence because the members work at the same hospital as the physician challenging their decisions and are his competitors in a small medical community).

107. Thomas J. Stipanowich, *The Arbitration Penumbra: Arbitration Law and the Rapidly Changing Landscape of Dispute Resolution*, 8 NEV. L.J. 427, 447 (2007).

108. See *Goals of Mediation*, MEDIATE.COM (2016), <http://www.mediate.com/divorce/pg13.cfm>.

109. See Tanya Glaser, *The Mediation Process: Practical Strategies for Resolving Conflict*, BEYONDIRTRACTABILITY.ORG (2016), <http://www.beyondintractability.org/bksum/moore-mediation>.

110. See *id.*

The largest downside of mediation is that there is no guarantee of an agreement. Again, an impasse could result where no agreement is reached between the parties.

At the other end of the spectrum, arbitration is the quasi-judicial process used when the parties are in need of a final determination to resolve the dispute.¹¹¹ This allows for a due process hearing conducted by a neutral third party, who, after hearing testimony and cross-examination, renders an award that is generally binding on the disputing parties.¹¹² The award may have a decision attached that explains the award to various degrees, up to that of an appellate decision in litigation. Advantages of arbitration (over traditional litigation) include that the process is often faster, less expensive, and can be organized in a fashion desired by the parties (with respect to discovery, evidence, witnesses, and even the conduct of the hearing or the selection of the arbitrator).¹¹³ More importantly, the process can be confidential and avoids the public record created by litigation.¹¹⁴

B. Is the Purpose of Peer Review and HCQIA Quality or Improvement?

As noted earlier, “[t]he purpose of this legislation is to improve the quality of medical care by encouraging physicians to identify and discipline other physicians who are incompetent or who engage in unprofessional behavior.”¹¹⁵ A distinction ought to be made between the two distinct objectives of the legislation. If improvement of the quality of medical care is primary, the process used may be very different from that used to discipline incompetent and unprofessional physicians.

In advocating the use of mediation, Edward A. Dauer and Leonard J. Marcus discussed the use of mediation to resolve medical

111. Stipanowich, *supra* note 107, at 427.

112. *About Mediation and Other Methods of Dispute Resolution*, BOSTONLAWCOLLABORATIVE.COM, <http://bostonlawcollaborative.com/blc/faqs/about-mediation-and-other-methods-of-dispute-resolution.html> (last visited July 21, 2016).

113. *Id.*

114. *Id.*

115. H.R. REP. NO. 99-903 (1986), 1986 WL 31972.

malpractice disputes.¹¹⁶ In medical malpractice cases, the objective is to provide some sort of remedy to the victims or beneficiaries of the physician's inappropriate activity.¹¹⁷ Essentially, the tort of negligence occurs when a doctor commits an act that results in harm to the patient.¹¹⁸ In traditional litigation, the typical remedy would be money damages.¹¹⁹ Mediation, however, has often led to a variety of outcomes such as an apology, recognition of errors made, an understanding of the patient's perspective, and frequently a change in methods of practice or procedure by the medical provider.¹²⁰

The effort of quality improvement "is by contrast a 'backward march of whys' inquiring about the underlying causes of errors to determine where changes can be made for the future."¹²¹

The strategy of quality improvement system design, by contrast, is to recognize that errors occur, to recognize that people work within systems, and to design the systems to do two things: (1) to make it difficult for individuals to make errors and (2) to make the whole system capable of "absorbing" individuals' errors when they occur by identifying and correcting errors before they can be harmful. Even when a doctor has committed an error of judgment or skill, a systems approach demands to know how and why that infraction came about.¹²²

If peer review and HCQIA are to focus on quality improvement, mediation seems to offer the best alternative. A neutral mediator can assist the parties to focus on the future, rather than address exclusively the past. Instead of merely assessing blame or fault, the parties will be free to direct their efforts at preventing the problem from reoccurring.

Patients' perceptions often determine how they view the quality of the medical services provided. Those perceptions may be the result of a misunderstanding between the doctor and patient, or a

116. Edward A. Dauer & Leonard J. Marcus, *Adapting Mediation to Link Resolution of Medical Malpractice Disputes with Health Care Quality Improvement*, 60 L. & CONTEMP. PROBS. 185 (1997).

117. *Id.*

118. *See id.* at 199.

119. *Id.* at 201.

120. *Id.* at 199.

121. *Id.* at 194-95.

122. *Id.* at 195.

miscommunication that leads the patient to be offended by the poor *bedside manner* of the health care provider. The physician may have no idea that he or she offended the patient by the way they spoke or dealt with their issues. If peer review took on the characteristics of mediation, an exchange between peers could lead to a better understanding of the issues and how they might be addressed going forward:

For its part, mediation, when properly employed, can be private, integrative, safe, nonjudgmental, and flexible in scope, process and outcome. It can be a safe harbor with therapeutic potential, and can offer its participants the opportunity to address the source as well as the consequence of the immediate problem. Mediation may, in short, offer a process whose traditional attributes are consistent with, rather than antithetical to, the requisites of quality improvement.¹²³

C. *Is the Purpose of Peer Review and HCQIA to Discipline Physicians?*

If the purpose of peer review and HCQIA is primarily to discipline incompetent and non-professional physicians, then a form of arbitration would be more appropriate. HCQIA requires that any hearing must be conducted by an arbitrator, a hearing officer or panel of individuals who are not in direct competition with the physician.¹²⁴

Arbitrators or other neutrals could be determined in advance, or there could be ad hoc appointment of arbitrators from associations such as the American Arbitration Association, Judicial Arbitration and Mediation Services, Endispute, or the National Center for Dispute Resolution. Alternatively, if no agreement could be reached, hospitals and physicians could also elect to use individuals or panels from these associations by mutual agreement or appointment.

Protocols could be developed to address admission to the panel, maintaining neutrality, and most importantly, training needed to serve in this capacity and in understanding complex issues in the delivery of health care. Physicians and hospitals would have a role in determining the expertise and/or credentials needed to serve as an arbitrator. In this regard, the parties have the advantage of having a

123. *Id.* at 199.

124. 42 U.S.C.A. § 11112(b)(3)(A)(i)–(iii) (Westlaw 2016).

true expert in the position of decision-maker (unlike trial judges of general jurisdiction). They would also have the power to review, with the arbitration association, the record of the arbitrator and the possibility of removing the arbitrator for conflicts of interest or inappropriate conduct.

The arbitral process could be designed by the parties themselves, addressing every aspect of peer review (within the strictures of HCQIA), including the nature of the hearing, the due process requirements, and the proposed outcomes. The type of arbitral award and the scope of review could also be addressed.

D. Perhaps an Optional Approach?

Given the alternatives of mediation and arbitration, and the characteristics of each that may incorporate peer-review procedures, it may make sense to bifurcate the process by the types of issues. For example, if the issue deals with problems in the delivery of health care resulting from the physician's conduct, then a mediation approach would seem to be the best alternative to prevent it from happening again. By contrast, if the issue deals with a physician whose conduct was so outrageous that his or her continued practice is called into question, then it appears that a form of arbitration would be best. The difficulty will be in deciding what type of case is at issue before beginning peer review.

E. Additional Training May Be Necessary.

As the peer review process expands to external peer review neutrals, the question of competence in both dispute resolution and in health care regulatory compliance becomes an issue. When an external neutral is utilized, does that mediator or arbitrator have the ability to deal with the volume of concerns facing health care providers, from privacy and security of handling personal health information to an understanding of appropriate medical procedures? The Model Standards of Conduct for Mediators (Promulgated by the American Bar Association, ADR Section; the American Arbitration Association, and the Society of Professionals in Dispute Resolution) provides in Standard IV: "Competence: A mediator shall mediate only when the mediator has the necessary competence to satisfy the reasonable expectations of the parties."¹²⁵ Similarly, the ABA/AAA Code of Ethics for Arbitrators requires the highest level of

125. MODEL STANDARDS OF CONDUCT FOR MEDIATORS (AM. BAR ASS'N 2015).

competence for arbitrators. Therefore, neutrals, though competent in dispute resolution processes, must also be subject-matter experts to serve in peer review in this ever complicated health care arena.

If the peer review neutral has his or her primary expertise in the health care profession, he or she must also develop the skills to be a mediator or arbitrator. This would entail the ability to conduct a due-process hearing, rule on evidentiary issues, and to be able to render an award if serving as an arbitrator. If functioning as a mediator, the third-party must have the skill to discern the issues involved, the respective interests of the parties, and to assist in formulating mutually-agreed-upon solutions. It is often said that this entails more of an art than a science. Provider agencies will be able to provide training for those health care professionals to also serve as third-party neutrals.

V. HCQIA AND PRIVACY.

In the professional peer-review hearings, patient health care records can often be a useful tool for physicians. For example, if a doctor is accused of not following certain hospital standards and is referred to a peer-review hearing, he or she may wish to produce patient records of other doctors in his practice in order to prove that the treatment or level of care he or she provided was not substandard.

When patient records are being transmitted or disclosed to a third party, HIPAA will be a concern.¹²⁶ HIPAA defines and limits the circumstances in which protected health information may be used or disclosed by covered entities.¹²⁷ The interplay that arises between HCQIA and HIPAA presents a pressing issue: while the medical peer review and HIPAA both aim to promote “high quality healthcare,” HIPAA tries to protect patient privacy and the peer-review process aims to give the medical community the tools to resolve disputes internally.¹²⁸ Because there is a complex interplay between these two rules, it is important for health care practitioners to have a robust compliance system to ensure that peer reviews are given the proper information without running afoul of HIPAA disclosure prohibitions.

126. 42 U.S.C.A. § 1320a-7e(b) (Westlaw 2016).

127. *Id.*

128. 42 U.S.C.A. § 1320c-9(a) (Westlaw 2016).

A. *The 500 Pound HIPAA in the Peer Review Room.*

Importantly, HIPAA and HCQIA do not technically conflict; however, the purpose of HIPAA is, as one court put it, “to safeguard individually identifiable health information . . . and while patients enjoy heightened privacy protection, covered entities . . . must adhere to the significant, time-consuming, often convoluted, and administratively and precedentially undeveloped compliance requirements.”¹²⁹ HCQIA, on the other hand, specifically requires the free exchange of information.¹³⁰ In *Freilich v. Upper Chesapeake Health, Inc.*,¹³¹ the Court specifically noted that the underlying purpose of HCQIA was to ensure that unscrupulous and incompetent doctors could not simply move to a new state and begin practicing medicine:

The legitimacy of Congress’s purpose in enacting the HCQIA is beyond question. Prior to enacting the HCQIA, Congress found that “[t]he increasing occurrence of medical malpractice and the need to improve the quality of medical care . . . [had] become nationwide problems,” especially in light of “the ability of incompetent physicians to move from State to State without disclosure or discovery of the physician’s previous damaging or incompetent performance.” 42 U.S.C. § 11101. The problem, however, could be remedied through effective professional peer review combined with a national reporting system that made information about adverse professional actions against physicians more widely available.¹³²

Thus, the two laws have competing purposes: HCQIA seeks to allow the free flow of information among regulatory bodies, whereas HIPAA seeks to limit disclosure of information.

Indeed, as stated above, there is no direct legal conflict between the two rules; the HIPAA privacy rule protects all individually identifiable health information held or transmitted by a covered entity

129. *United States ex rel. Pogue v. Diabetes Treatment Ctrs. of Am.*, 2004 WL 2009416, at *5 (D.D.C. May 17, 2004).

130. *Freilich v. Upper Chesapeake Health, Inc.*, 313 F.3d 205, 212 (4th Cir. 2002).

131. *Id.* at 205.

132. *Id.* at 211.

or its business associate in any form or media.¹³³ The rule prohibits an entity from using or disclosing protected health information unless authorized by patients but specifically creates an exception where this prohibition would result in unnecessary interference with access to quality health care or with certain other important public benefits or national priorities.¹³⁴ This includes the disclosure of protected information for “treatment, payment, or health care operations.”¹³⁵ A peer review conducted pursuant to the rules and procedures of HCQIA would be considered a “health care operation” and exempt from the anti-disclosure provisions of the HIPAA privacy rule.

In fact, the two statutes have even been considered as part of a single statutory framework governing health care.¹³⁶ In at least one case, albeit unreported, the Eastern District of Tennessee stated that HIPAA and HCQIA, although enacted at different times pertained to the same subject.¹³⁷ Thus, they should be interpreted in light of each other since they have a common purpose related to health care policy:

Because the HIPDB [HCQIA] and the relevant provisions of HIPAA were modeled after the NPDB and the relevant provisions of HCQIA, however, the two statutes are to be considered in *pari materia*. Accordingly, and for purposes of the Motion before it, the Court will construe the statutes and their respective corresponding regulatory frameworks as such, and will consider judicial interpretations of relevant provisions of the HCQIA and NPDB as persuasive with regard to identical or similar provisions of the HIPAA and HIPDB.¹³⁸

The court ultimately concluded that neither HIPAA nor HCQIA gave rise to a private right of action.¹³⁹ Importantly, the court reached this conclusion by considering the two laws together and finding that case law interpreting HIPAA is instructive in interpreting HCQIA,

133. 45 C.F.R.A. § 164.502(a) (Westlaw 2016).

134. § 164.502(b)(2).

135. § 164.506 (otherwise known as the “T.P.O.” exception).

136. *Carter v. Bluecross Blueshield of Tenn.*, 2006 WL 1129390, at *1 n.1 (E.D. Tenn. Apr. 24, 2006).

137. *Id.*

138. *Id.*

139. *Id.* at *5.

and vice-versa.¹⁴⁰ Thus, the interplay between HIPAA and HCQIA is complex—despite often competing goals, the two statutes can be reconciled and interpreted together as a single regulatory whole.

B. Privacy and Litigation: How Far Does the Peer Review Privilege Extend?

The difficulties involving privacy issues do not arise from the peer review. Instead, privacy issues emerge during subsequent lawsuits in which physicians seek to discover or disclose information that was disclosed during the peer-review process. Most commonly, these cases are in the form of a medical malpractice suit filed by the patient, and implicate state law peer-review enactments, which most state legislatures have passed.¹⁴¹

In Michigan, for example, the legislature enacted Michigan Compiled Laws § 331.531.¹⁴² The purpose of this statute was to “foster the free exchange of information in investigations of hospital practices and practitioners, and thereby reduce patient mortality and improve patient care within hospitals.”¹⁴³ These peer-review statutes often provide qualified immunity to protect peer-review committee reports. The findings of these peer reviews are often also reported to the National Practitioners Data Bank, which is accessible by hospitals and other entities throughout the country but not available to the general public.¹⁴⁴

The recent Michigan Supreme Court ruling in *Krusac v. Covenant Medical Center*¹⁴⁵ is an excellent exemplar of the interplay between peer review and privacy issues. This case also represents the complex health care policy issue related to a patient’s right to know and the confidentiality of the peer-review process.¹⁴⁶ *Krusac*

140. *Id.*

141. Kym Oltrogge, Note, *An Ounce of Prevention is Worth a Pound of Cure: The Need for States to Legislate in the Area of Hospital Professional Review Committee Proceedings*, 46 WASH. & LEE L. REV. 961, 993 n.192 (1989).

142. MICH. COMP. LAWS ANN. § 331.531 (Westlaw 2016) (originally enacted in 1980).

143. *Feyz v. Mercy Mem’l Hosp.*, 475 Mich. 663, 666 (2006) (HIPAA, too, provides that administrators furnish information to “the National Practitioner Data Bank established pursuant to the Health Care Quality Improvement Act of 1986 (42 U.S.C.A. 11101 et seq.)”); 42 U.S.C.A. § 1320a-7e (Westlaw 2016).

144. *Frengell v. Intercare Cmty. Health Network*, 2010 WL 4483656 (Mich. Ct. App. Nov. 9, 2010).

145. 497 Mich. 251 (2015).

146. *See id.*

involved a medical-malpractice suit brought by the representatives of a woman who had died shortly after “roll[ing] off the operating table” during a cardiac catheterization.¹⁴⁷ After the incident, Covenant Medical Center had created an incident report for the purpose of conducting a peer-review investigation under Michigan’s HCQIA analog.¹⁴⁸ The plaintiff sought to have the trial court conduct an in-camera review of the report and, while keeping the report confidential, “provide plaintiff with the facts contained in it.”¹⁴⁹ The trial court agreed, and provided the plaintiff with the facts but not the conclusions or actions taken as a result.¹⁵⁰

On appeal, the Michigan Supreme Court overruled a prior appellate court case.¹⁵¹ That case, *Harrison v. Munson Health Care, Inc.*,¹⁵² said that the peer-review privilege in Michigan did not cover “[o]bjective facts gathered contemporaneously with an event,”¹⁵³ by reasoning that “[t]o hold otherwise would grant risk managers the power to unilaterally insulate from discovery firsthand observations that the risk managers would prefer remain concealed. The peer review statutes do not sweep so broadly.”¹⁵⁴ The Michigan Supreme Court disagreed; explicitly overruled *Harrison*; and held that all records, data, and knowledge collected in a medical peer review, in furtherance of its statutorily mandated purpose, will remain private and privileged.¹⁵⁵

State courts are divided on this very question. While Michigan has ruled that its peer-review statute broadly protects both factual findings and conclusions made in a peer-review report, other states have limited the privilege to the material conclusions of such peer reviews.¹⁵⁶ In Arizona, the peer-review enactment is found in ARIZ.

147. *Id.* at 254.

148. *Id.*

149. *See id.*

150. *Id.* at 255

151. *Id.* at 263.

152. 304 Mich. App. 1 (2014).

153. *Id.* at 32.

154. *Id.* at 34.

155. *Krusac*, 497 Mich. at 263.

156. *Compare id.* (stating, “all records, data, and knowledge collected for or by a peer review committee . . . “ are privileged.) *with* *John C. Lincoln Hosp. & Health Ctr. v. Super. Ct. ex rel. Maricopa*, 159 Ariz. 456, 459 (1989) (relying on ARIZ. REV. STAT. ANN. § 36-445.01(A) (Westlaw 2016) and ruling that only “‘discussions, exchanges, and opinions’ or ‘proceedings, records and materials prepared in connection with the review[s]’” are protected by privilege).

REV. STAT. ANN. §§ 36–445 et seq.¹⁵⁷ and the state courts there have, indeed, found that the act does not protect “raw factual information which may trigger such discussions, exchanges and opinions.”¹⁵⁸ On the other hand, a federal court in Georgia described the complete privilege of peer-review reports with particular eloquence, holding, “[i]n short, the peer review statutes confer upon peer review organizations the qualities of a black hole; what goes in does not come out, and, unless the information exists in duplicate in the surrounding orbit, nothing that went in is discoverable.”¹⁵⁹ Since medical malpractice cases are most often brought under state law, practitioners must be cognizant of the rule in their particular jurisdiction.

C. *NPDB Reports: Confidential but Discoverable.*

Courts often weigh a conflict between the need for privacy and the need for full disclosure of information. In the HCQIA context, this conflict often arises in the discovery of the NPDB incident reports, themselves. HCQIA provides a general restriction on disclosure of the reports. However, hospitals are not only permitted to view reports regarding health care practitioners, they are required to do so whenever the “health care practitioner applies for a position on its medical staff (courtesy or otherwise) or for clinical privileges at the hospital;” moreover, the hospitals are required to, again, request this information “[e]very 2 years for any health care practitioner who is on its medical staff or has clinical privileges at the hospital.”¹⁶⁰ A derogatory NPDB report, therefore, can significantly impact a physician’s prospects for employment with, or staff privileging at a hospital. Consequently, practitioners have a significant incentive to dispute NPDB reports.

In addition, the NPDB may provide information, upon request, to “[a]n attorney, or individual representing himself or herself, who has filed a medical malpractice action or claim in a state or Federal court or other adjudicative body against a hospital, and who requests information regarding a specific health care practitioner who is also

157. ARIZ. REV. STAT. ANN. §§ 36–445 et seq. (Westlaw 2016).

158. See *John C. Lincoln Hosp. & Health Ctr. v. Super. Ct. ex rel. Maricopa*, 159 Ariz. 456, 459 (1989) (relying on *Humana Hosp. v. Super. Ct.*, 154 Ariz. 396 (1987)).

159. *Doe v. UNUM Life Ins. Co. of Am.*, 891 F. Supp. 607, 610 (N.D. Ga. 1995).

160. 45 C.F.R.A. § 60.17(a)(1), (2) (Westlaw 2016).

named in the action or claim.”¹⁶¹ The information may then be used “solely with respect to litigation resulting from the action or claim against the hospital.”¹⁶² Thus, there are two instances in which NPDB reports can be discovered: cases in which a doctor or health care practitioner challenges the accuracy of the report and cases in which a doctor’s qualifications or professional history are an issue in a claim or action.

In *Klaine v. Southern Illinois Hospital Services*, the Illinois Supreme Court discussed the difference between confidential information and discoverable information.¹⁶³ In that case, which was a medical malpractice action, Carol and Keith Klaine, the Plaintiffs, filed a malpractice action based on negligent credentialing of Dr. Frederick Dressen.¹⁶⁴ In discovery, the Plaintiffs sought discovery of Dr. Dressen’s NPDB file, which the Hospital used in deciding to provide Dr. Dressen with credentials.¹⁶⁵ The trial court agreed with the Klaines and ordered the file to be disclosed; the Hospital filed an interlocutory appeal, and after the appellate court affirmed the trial court’s order, the Hospital appealed to the Illinois Supreme Court.¹⁶⁶

The Illinois Supreme Court again affirmed the trial court’s holding.¹⁶⁷ The Court deftly explained the difference between confidentiality and discoverability, holding, “[i]nformation, though confidential, may be highly relevant to matters at issue in a trial and, therefore, critical to the truth-seeking process. Consequently, the confidential nature of information does not prevent it from being discoverable unless the plain language of the statute so provides.”¹⁶⁸ HCQIA does not specifically provide that the NPDB reports are undiscoverable. On the contrary, the law provides that “[n]othing in this subsection shall prevent the disclosure of such information by a party which is otherwise authorized, under applicable State law, to make such disclosure.”¹⁶⁹ Under Illinois law, the Court held, the hospital would have been required to produce “information with respect to the [P]laintiffs’ negligent credentialing claim,” including

161. *Id.* § 60.18(a)(1)(v).

162. *Id.*

163. *Klaine v. S. Ill. Hosp Servs.*, 47 N.E.3d 966, 968 (Ill. 2016).

164. *Id.*

165. *Id.*

166. *Id.*

167. *Id.* at 975.

168. *Id.* at 972.

169. 42 U.S.C.A. § 11137(b)(1) (Westlaw 2016).

the NPDB report.¹⁷⁰ Thus, the Court concluded that “information reported to the NPDB, *though confidential, is not privileged from discovery* in instances where, as here, a lawsuit has been filed against the hospital and the hospital’s knowledge of information regarding the physician’s competence is at issue.”¹⁷¹

VI. CONCLUSION

The HCQIA and its state analogs create a powerful set of tools to improve health care delivery across the country. However, such a broad law interacts in complicated ways with other rules and regulations. HCQIA has profound interactions with ADR procedures, HIPAA, and discoverability rules. Both health care and legal practitioners need to be cognizant of the jurisprudence in this area, particularly as health care is discussed, reformed, and practiced across the country.

170. *Klaine*, 47 N.E.3d at 974.

171. *Id.* at 975 (emphasis added).